Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ARLINGTON SURGICARE
2400 MATLOCK
ARLINGTON TX 76015

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-2904-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Implant charge was not paid according to WC Rule 134.402."

Amount in Dispute: $770.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Implants were reimbursed as follows:

Synthes small frag 3.5 x3 @ 27.45 each =	82.35
Synthes TI screw x 3 @ 27.22 each =	81.66
Sythes washer	401.98
Optimum Bone putty	850.00
Bioguide patch	350.00
Total	$1,765.99 plus 10% = $1,942.59."

"The provider billed the following items which are not implants but is seeking separate implant reimbursement:

Evicel kit:	$495.00
Graft syringe	$205.00

Evicel is a topical sealant and a bone graft syringe is an instrument. These items were denied as considered in the facility fee. I have attached the product information for these products."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17, 2011	HCPCS code L8699	$770.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 3, 2011

   - 97- Payment is included in the allowance for another service/procedure.
   - 150 Payment adjusted because the payer deems the information submitted does not support this level of service.

   Explanation of benefits dated April 15, 2011

   - 97- Payment is included in the allowance for another service/procedure.
   - 150 Payment adjusted because the payer deems the information submitted does not support this level of service.
   - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
   - B006-This charge is included in the ASC fee.

Issues

1. Is the requestor entitled to additional reimbursement for HCPCS code L8699?

Findings

1. The respondent denied reimbursement for the Evicel kit and Graft syringe based upon reason codes "97-Payment is included in the allowance for another service/procedure"; "150 Payment adjusted because the payer deems the information submitted does not support this level of service"; "Z652-Recommendation of payment has been based on a procedure code which best describes services rendered"; and "B006-This charge is included in the ASC fee".

   The respondent states in the position summary that "The provider billed the following items which are not implants but is seeking separate implant reimbursement:

Evicel kit:	$495.00
Graft syringe	$205.00

   Evicel is a topical sealant and a bone graft syringe is an instrument. These items were denied as considered in the facility fee. I have attached the product information for these products."

   28 Texas Administrative Code §134.402(b)(5), states "Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. (5) 'Implantable' means an object or device that is surgically:
   (A) implanted,
   (B) embedded,
   (C) inserted,
   (D) or otherwise applied, and
   (E) related equipment necessary to operate, program, and recharge the implantable."

   The requestor did not submit documentation to support that the Evicel kit and Graft syringe met the definition of "implantable" per 28 Texas Administrative Code §134.402(b)(5); therefore, the insurance carrier's denial is supported. Reimbursement cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor did not support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		4/12/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.